08/14/2012 17:22 4236394742 LCC OF GREENEVILLE PAGE 17/24 PRINTED: 07/28/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 445228 07/24/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET LIFE CARE CENTER OF GREENEVILLE GREENEVILLE, TN 37743 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) What corrective action (s) will be K 018: NFPA 101 LIFE SAFETY CODE STANDARD K 018 accomplished for those residents found to have 9/10/12 SS=D been affected by the deficient practice: Doors protecting corridor openings in other than a) All facility maintenance personnel required enclosures of vertical openings, exits, or were immediately in-serviced on hazardous areas are substantial doors, such as NFFA 101 Life Safety Code those constructed of 1% inch solid-bonded core Standards. wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only How you will identify other residents having required to resist the passage of smoke. There is the potential to be affected by the same defiant no impediment to the closing of the doors. Doors practice and what corrective action will be are provided with a means suitable for keeping taken: the door closed. Dutch doors meeting 19.3.6.3.6 All facility residents and visitors have are permitted. 19.3.6.3 the potential to be affected. Roller latches are prohibited by CMS regulations What measures will be put into place or what in all health care facilities. systematic changes you will make to ensure that the deficient practice does not recur: a) All facility maintenance personnel were in-serviced on NFPA 101 Life Safety Code Standards on 7/24/12. b) The Maintenance Director, and/or the Maintenance Assistant will assure compliance through daily rounds to assure proper closure and positive latch of corridor doors. This STANDARD is not met as evidenced by: Based on observation and interview, the facility How the corrective action(s) will be monitored failed to assure corridor doors closed to a positive to ensure the deficient practice will not recur; latch. (NFPA 101, 19-3.6.3.)

The findings include:

Observation and interview with the Maintenance Director, on July 24, 2012 at 10:00 a.m. confirmed the corridor door to the Birch half clean linen room by room 21and the kitchen door to the employee break room failed to close to a positive latch.

This finding was acknowledged by the

- Maintenance Director, and/or the Maintenance Assistant, will make daily rounds to assure compliance and proper closure and positive latch of corridor doors.
- The Executive Director will assure compliance by making random daily rounds.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE DIFECTOR

8/10/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: YH5V21

Facility ID; TN3004

If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 R WING 445228 07/24/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET LIFE CARE CENTER OF GREENEVILLE **GREENEVILLE, TN 37743** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XI) COMPLETION DATE (X4) ₹D ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Results will be reported to the K 018 | Continued From page 1 facility's Executive Director and K 018 reported monthly to the Performance Administrator during the exit conference on July Improvement Committee. The Performance Improvement K 029 NFPA 101 LIFE SAFETY CODE STANDARD Committee will review the results \$S=E and; if deemed necessary by the One hour fire rated construction (with 1/4 hour committee, additional education may fire-rated doors) or an approved automatic fire be provided. The process may be extinguishing system in accordance with 8.4.1 evaluated/ revised and/or the audits and/or 19.3.5.4 protects hazardous areas. When reviewed for 3 months or until 100% the approved automatic fire extinguishing system. compliance is achieved. option is used, the areas are separated from e) Performance Improvement other spaces by smoke resisting partitions and Committee members are the doors. Doors are self-closing and non-rated or Executive Director, the Medical field-applied protective plates that do not exceed Director, the Director of Nursing, the 48 inches from the bottom of the door are Assistant Director of Nursing, the permitted. 19,3,2,1 MDS Coordinator, the PPS Nurse, the Rehab Service Manager, the Social Service Director, the Dietary Manager, the Pharmacist, the Maintenance Director, the Business This STANDARD is not met as evidenced by: Office Manager, the Housekeeping Based on observation and interview, the facility Supervisor, the Staff Development failed to assure hazardous area 's one (1) hour Coordinator and the Wound Care fire rated construction is maintained. Nurse. . The findings include: Observation and interview with the Maintenance What corrective action (s) will be Director, on July 24, 2012 at 9:10 a.m. confirmed accomplished for those residents found to have 9/10/12 K029 unsealed penetrations in the following areas: been affected by the deficient practice: 1) Conduit and cable lines in the ceiling of the a) All facility maintenance personnel were FACP closet. immediately in-serviced on NFPA 101 2) Sprinkler riser room ceiling, Life Safety Code Standards. 3) Main electrical room, conduit above the b) All penetration areas listed have been Automatic Transfer Switch (ATS) was sealed with sealed with fire rated caulk on 7/24/12. a non-approved fires top material (sheetrock Door closer placed on emergency supply mud). room door in kitchen on7/24/12. Dry goods storage room door has been d) Based on observation and interview, the facility ordered 8/10/12 and will be installed upon failed to assure rooms larger than 50 square feet, arrival. used to store combustible materials, were

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN' AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MU A. BUILO	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	URVEY ETED
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K 058 SS=D	Director, on July 24 confirmed the kitch was not provided w 19.3.2.1 (7) and the not provided with a drawings. These findings wer Supervisor and ack Administrator durin 24, 2012. NFPA 101 LIFE SA If there is an autominstalled in accorda for the Installation oprovide complete obuilding. The syste accordance with Nf Inspection, Testing Water-Based Fire I supervised. There supply for the syste systems are equipped.	closers. e: terview with the Maintenance l, 2012 at 10:15 a.m. en emergency supply room with a door closer (NFPA 101, e dry goods storage room was door as shown on the building e verified by the Maintenance knowledged by the g the exit conference on July affety CODE STANDARD matic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water and, Required sprinkler and with water flow and tamper a electrically connected to the	K 02	How you will identify other retthe potential to be affected by the practice and what corrective actaken: a) All facility residents a the potential to be affected by the practice and what corrective actaken: a) All facility residents a the potential to be affected by a facility maintenance were in-serviced on N Safety Code Standards by 100% of facility was confurther areas of concertion of the Maintenance Direction of the Maintenance Assistant random rounds to more compliance. How the corrective action(s) with the the deficient practice and the deficient practice. How the corrective action(s) with the consument the deficient practice of the maintenance Assistant rounds to monitor dail by the Executive Directo compliance by making rounds. c) Results will be reported facility's Executive Director monthly to the Improvement Committed the Performance Improcommittee will review.	tion will be and visitors have beted. place or what ake to ensure not recur: the personnel FPA 101 Life to no 7/24/12. The cked and no to were found. The ctor, and/or the the will make the will make the will make the ctor, and/or the the will make the will make the compliance. The will assure the daily random the the rector and to the trector and to the trector and the rector and	
	Based on observat			and; if deemed necessare committee, additional of the provided. The proceed and reviewed for 3 months compliance is achieved	education may ess may be for the audits or until 100%	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01	(X3) DATE SUI COMPLET	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056 K 130 SS=D	Director on July 24, the alcove at the elewith sprinkler protect. This finding was ac Administrator during 24, 2012. NFPA 101 MISCEL OTHER LSC DEFICE This STANDARD is Based on observational failed to assure that accessible. The findings include Observation and re Director, on July 24 confirmed the fire him was not clearly visit department access This finding was accessible finding was accessible finding was access this finding was access the statement access the sta	perview with the Maintenance 2012 at 11:30 a.m. confirmed extrical room was not provided ction. knowledged by the grant conference on July LANEOUS CIENCY NOT ON 2786 Is not met as evidenced by: ion and interview, the facility the fire hydrants were cord with the Maintenance, 2012 at 11:00 a.m. ydrant in front of the building ole and was obstructed for fire by landscaping.			How the corrective action(s) will to ensure the deficient practice were as Maintenance Director, a Maintenance Assistant, rounds to monitor daily and to assure the sprinkle maintained. b) The Executive Director compliance by making rounds. c) Results will be reported facility's Executive Director reported monthly to the Improvement Committee. d) The Performance Improve Committee, additional educes be provided. The process evaluated revised and/or reviewed for 3 months or compliance is achieved. c) Performance Improveme Committee members are Executive Director, the Director of Num MDS Coordinator, the Prechab Service Manager, Service Director, the Office Manager, the Pharmacist Maintenance Director, the Office Manager, the Hou Supervisor, the Staff Dev Coordinator and the Woo Nurse.	Ill not recur: and/or the will make compliance er system is will assure andom daily to the eter and derformance ement he results by the lication may is may be the audits fedical Nursing, the raing, the PS Nurse, the the Social tarry the Business sekeeping relopment	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Observation and interview with the Maintenance Director on July 24, 2012 at 11:30 a.m. confirmed the alcove at the electrical room was not provided with sprinkler protection. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012. K 130 OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that fire hydrants were accessible. The findings include: Observation and record with the Maintenance Director, on July 24, 2012 at 11:00 a.m. confirmed the fire hydrant in front of the building was not clearly visible and was obstructed for fire department access by landscaping. This finding was acknowledged by the Administrator during the exit conference on July 24, 2012.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	-	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE \$1,	
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b) The Executive Director will assure compliance by making random daily rounds.	K 056	Continued From participation of the alcove at the elewith sprinkler profect This finding was acted. Administrator during 24, 2012. NFPA 101 MISCEL OTHER LSC DEFICE This STANDARD is Based on observatifailed to assure that accessible. The findings include Observation and reconfirmed the fire hywas not clearly visible department access. This finding was acted. Administrator during	ge 3 terview with the Maintenance 2012 at 11:30 a.m. confirmed actrical room was not provided ction. knowledged by the g the exit conference on July LANEOUS CIENCY NOT ON 2786 s not met as evidenced by: ion and interview, the facility it fire hydrants were a: cord with the Maintenance , 2012 at 11:00 a.m., ydrant in front of the building ble and was obstructed for fire by landscaping. knowledged by the	!		What corrective action (s) will be accomplished for those residents been affected by the deficient pre immediately in-serviced 101 Life Safety Code St b) Landscaping will be cle visibility and fire depart to fire hydrant. How you will identify other resid the potential to be affected by the practice and what corrective action the potential to be affected. What measures will be put into p systematic changes you will make that the deficient practice does not a) All facility maintenance were in-serviced on 7/24 101 Life Safety Code St b) The Maintenance Direct the Maintenance Direct the Maintenance Assistant random rounds to monit compliance. How the corrective action(s) will to ensure the deficient practice will be ensured to monitor defined to the process of the precess of the process of the process of the process of the process	found to have actice: resonnel were on NFPA andards. ared for ment access cents having a same defiant on will be active and active at recur: personnel and ards. or, and for and ards. or, and for and my will make or daily be monitored and or the will make compliance as will assure	9/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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